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**Kingsley Asare, DO, MPH
Board Certified Internal Medicine
Board Certified Infectious Disease**

**Michael Schaefer, DC, MPH, DACACD
Board Certified Addictions and Compulsive Disorders**

Welcome to the Clinic! We focus on individualized medical care that recognizes the interactions between genetic and environmental factors and between the body's interconnected systems. **We do not prescribe controlled substances for chronic pain.** We are honored that you have chosen us to help in your search for optimum health. This is your New Patient Information Packet. **Please read, fill out and sign the attached forms.** We are an appointment only clinic however we strive to offer same day appointments when you are sick. If you have an emergency call 911 or go to your nearest emergency room then once you are stable contact our office. If you need to cancel or reschedule your appointment, please notify our office **24 hour** or more before your appointment. **We charge \$40.00 fee missed appointment if less than 24 hour notice is given.** We require a credit card on file which will be charged in the event you do not show for your appointment or cancel 24 hours prior. Please provide a phone number you wish us to call when we need to contact you. *If you have an answering machine or voice mail, a message will be left unless you cross out this section out and initial _____.* In some cases the doctor may request fasting lab tests, so we ask that you have no food 8 hours prior to your lab appointment. **Please do not fast, if you have diabetes, hypoglycemia or simply cannot do so.** If you have any questions please call our office at (727) 729-9000. We look forward to meeting you!

Please tell us how you were referred to us _____ Date _____

Name _____ Birthdate _____
Last First Middle Initial

Address _____
Street City State/Prov. Zip/Postal code

Telephone: Home _____ Cell _____ Work _____

Email _____ Insurance name and policy # _____

Primary insured name and date of birth if other than patient _____

Employed by _____ Occupation _____

Age: _____ Height: _____ Weight: _____ Gender: (Female) (Male) (L) (R) Handed

Emergency contact _____
Name Telephone Address

1. What is your current gender identity? (Check and/or circle ALL that apply)

- Male
- Female
- Transgender Male/Transman/FTM
- Transgender Female/Transwoman/MTF
- Genderqueer
- Additional category (please specify): _____
- Decline to answer

2. What sex were you assigned at birth? (Check one)

- Male
- Female
- Decline to answer

List the main problems that you are having, or reason for this appointment (example): Headache, Cold, Anxiety, Substance Abuse, Stomach problems, Fever, Infectious problems, Wound care, Neck or Back Pain etc... If an accident include date of accident: (Motor vehicle accident) (Slip & Fall) Please explain in detail (Please ask for additional page/s if necessary) _____

Past Medical History (Major Past Illnesses): Hepatitis A, B, or C, HIV, Syphilis, Stroke, Heart attack, etc:

Have you ever been tested for HIV? (YES) (NO)

Would you like to be tested for HIV? (Yes) (No)

Have you ever been tested for Hepatitis A, B, or C? (YES) (NO)

Would you like to be tested for Hepatitis A, B, or C (Yes) (No)

Prior accidents or major trauma (Scars –Please give location) List current accident also even if this is the reason for today’s visit. _____

Hospitalizations/Surgeries – please give month/year if possible:

Dental Procedures (root canals, ect.)

Current Prescription Medications (names and doses):

Allergies and Sensitivities: Foods, environmental, etc.–Ever tested? Copies of reports?

Occupational Exposures:

SOCIAL HISTORY:

Your Lifestyle factors (Please fill in the approximate amounts example Daily 1 pack, 3 drinks etc.):

	Never	Occasional	Weekly	Daily
Coffee				
Tobacco				
Alcohol				
Opiates				
THC				
Cocaine				

If you smoke or use Tobacco Do you want to quit? (YES) (NO)

Does anyone in the family smoke? (YES) (NO)

Inside the home? (YES) (NO)

- Have you felt you need to **cut** down on your drinking? (Y) (N)
- Have you ever felt **annoyed** by criticism of your drinking? (Y) (N)
- Have you felt bad or **guilty** about your drinking? (Y) (N)
- Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (**eye-opener**)? (Y) (N)

During the **past three months**, how often have you failed to do what was normally expected of you because of your use of alcohol (beer, wine, spirits, etc.)? (never) (1-2 times) (monthly) (weekly) (daily)

During the past month, have you often been bothered by feeling down, depressed, or hopeless? (Y) (N)

During the past month, have you often been bothered by little interest or pleasure in doing things? (Y) (N)

GAD-7 Anxiety Severity (0-21 : 5/10/15 mild, moderate, and severe anxiety). **Please answer all questions.**

0—not at all, 1—several days, 2—more than half the days, and 3—nearly every day, respectively

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several Days (2-3 days a week)	More than half the days (4-5 days a week)	Nearly every day (6-7 days a week)
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T ____ = ____ + ____ + ____)

Do you feel like you are overweight? (Y) (N)

If yes would you like to get to a healthier weight? (Y) (N)

Exercise Activities

Never Minutes Hours Weekly Daily

Swim _____

Run _____

Walk _____

Dance _____

Bike _____

Garden _____

Golf _____

Tennis _____

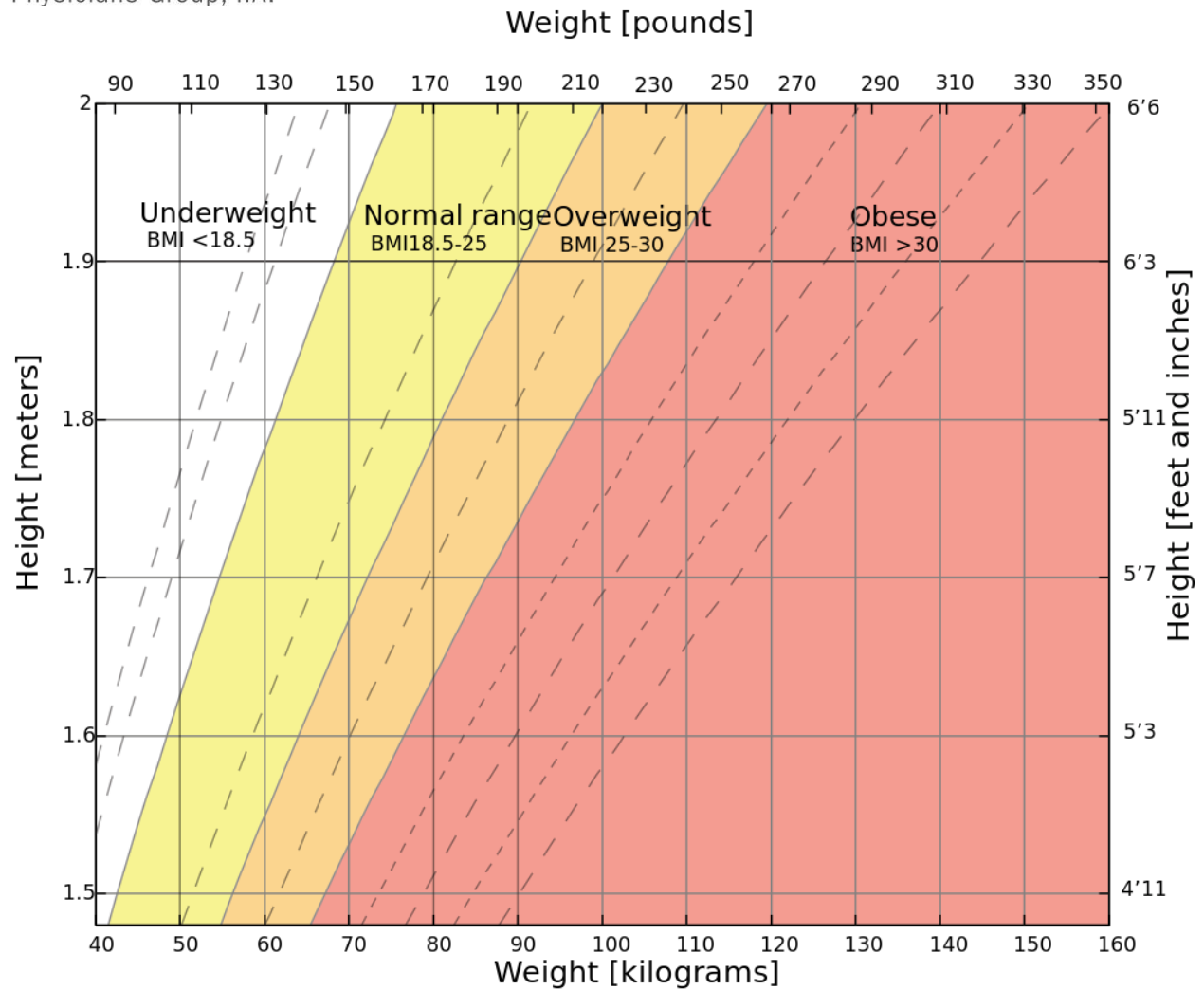
Ski _____

Weights _____

Other _____

Answering the following statements help us determine whether you should have your hearing evaluated. >2+	No	Sometimes	Often
1. I hear but I don't always understand what others are saying.			
2. I have trouble hearing when people speak softly.			
3. I have trouble understanding someone if they are speaking in a different room			
4. I have trouble hearing others speak when they are not facing me			
5. People tell me to turn down the TV			
6. I find it hard to hear when I am in a group setting			
7. I have difficulty catching most of the words when I go see a play or movie			
8. I have trouble hearing on the telephone.			
9. I have trouble hearing others when I am at a restaurant.			
10. I have trouble making out the words in songs.			

PLEASE LIST ANY VITAMIN, MINERAL, AMINO ACID, OTHER SUPPLEMENTS OR MEDICATION THAT YOU MAY BE TAKING. **SUPPLEMENTS MANUFACTURER FORM DOSAGE FREQUENCY** EXAMPLE: VITAMIN C TABLET 250 MG, 2 PER DAY



MOOD ASSESSMENT SCALE answer all n 0-9; md 10-19; sd 20-30	YES	NO
1. Are you basically satisfied with your life?		
2. Have you dropped many of your activities and interests?		
3. Do you feel that your life is empty?		
4. Do you often get bored?		
5. Are you hopeful about the future?		
6. Are you bothered by thoughts you can't get out of your head?		
7. Are you in good spirits most of the time?		
8. Are you afraid that something bad is going to happen to you?		

9. Do you feel happy most of the time?	Yes	No
10. Do you often feel helpless?		
11. Do you often get restless and fidgety?		
12. Do you prefer to stay at home, rather than going out and doing new things?		
13. Do you frequently worry about the future?		
14. Do you feel you have more problems with memory than most?		
15 Do you think it is wonderful to be alive now?		
16 Do you often feel downhearted and blue?		
17 Do you feel pretty worthless the way you are now?		
18 Do you worry a lot about the past?		
19 Do you find life very exciting?		
20 Is it hard for you to get started on new projects?		
21 Do you feel full of energy?		
22 Do you feel that your situation is hopeless?		
23 Do you think that most people are better off than you are?		
24 Do you frequently get upset over little things?		
25 Do you frequently feel like crying?		
26 Do you have trouble concentrating?		
27 Do you enjoy getting up in the morning?		
28 Do you prefer to avoid social gatherings?		
29 Is it easy for you to make decisions?		
30 Is your mind as clear as it used to be?		

IMMUNIZATIONS

Flu: YEAR _____

Varicella (chickenpox): YEAR _____ HAD VACCINE (Y) (N) HAD CHICKENPOX (Y) (N)

PPD (test for tuberculosis test) _____

CHILDHOOD VACCINATIONS (Y) (N)

Prior or current treating DOCTOR. Please list all chiropractors, osteopaths, allopathic, podiatrists, optometrists, etc. _____

How did you hear about us (who referred you) _____

if your physician referred you or you have a specialist or primary care physician please list below so we can forward notes to them.

Name, address and fax #: _____

Family Medical History

Please give age, lists of any illness, or if deceased. If deceased, list cause of death and age of death.

Mother (M) Age: _____ Father (F) Age: _____

Possible Illnesses

Allergies (M) _____ (F) _____

Asthma (M) (F) Diabetes (M) (F) Diabetes-Age at Onset _____ Epilepsy (M) (F)

Heart Disease (M) (F) Bleeding Tendency (M) (F) Glaucoma (M) (F) Chrons Disease (M) (F)

Cancer (F) (yes) (no) If yes type: (Prostate) (Lung) (Liver) (GI) (Brain) other: _____

Cancer (M) (yes) (no) If yes type: (Breast) (Cervix) (Ovary) (Lung) (Liver) (GI) (Brain) other: _____

Bleeding Tendency (M) (F) Glaucoma (M) (F) Crohn's Disease (M) (F) Drug Abuse (M) (F)

Alcohol Consumption Abuse (M) (F) Gall Bladder (M) (F) Liver Disease (M) (F)

Hypoglycemia (M) (F) Hearing Loss (M) (F) Kidney Disease (M) (F) Lupus (M) (F)

Thyroid Disease (M) (F) Mental Illness (M) (F) Multiple Sclerosis (M) (F) Rheumatoid Arthritis (M) (F)

Tuberculosis (M) (F) Skin Disease (M) (F) Other Conditions _____

Brothers and Sisters: Age and illness if applicable for each: _____

Mother's Parents illness: _____

Father's Parents illness: _____

Children: _____

Highest level of school you completed: (6) (7) (8) (9) (10) (11) (12 HS) (College) (Master) (Doctorate)
(Single) (Married) (Divorced) Children (1) (2) (3) (4) (5) _____

Current living environment: (Apartment) (House) other: _____

Major support system/s: (friend) (Spouse) (family) other: _____

Are there any conditions that were not included? (Y) (N) If so please include
below: _____

*** HIPAA policy:** This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment and healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. Protected health information is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition related health care services.

Uses and Disclosures of staff and others (business associates) that are involved your treatment, payment, and healthcare operations and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to home health agency that provides care to you or diagnostic facility, or a physician that we have referred you to or who referred you to our office.

Payment: Your PHI will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for treatment, or a hospital stay which may require that relevant protected health information to be disclosed to the health plan to obtain approval for the treatment.

Healthcare Operations: We may use or disclose as needed, your PHI in order to support business activities of your physician's practice. These activities includes, but not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging of other business activities. For example we may disclose your PHI to medical students that see patients at our office. In addition we may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situations without your authorization. These situations include: as required by law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the Law, we must make disclosures to you

disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with requirements HIPAA privacy rule section 164.500

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or physician's practice has taken an action on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; substance abuse notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to PHI.

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved with your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any of your protected health information.

We reserve the right to change the terms of the notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your policy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint.

We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on or before August 01, 2013

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information (PHI). If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main number (727) 729-9000.

Signature below is only acknowledgement that you have read and understand our Notice of our Privacy Practices:

Very Important Information *

Please Read Carefully, Initial and Sign After Reading

We at Advanced Care Physicians Group, P.A. are here to help you take care of your health in the best way that we know how. We realize you came in about health and not finances. The following is to assist you in understanding that our Clinic financial policies. We maintain privacy of your medical records/information and this will serve as your notification of this. Anytime you would like to review privacy practices please feel free to make an appointment and go over any questions that you have. We reserve the right to change those terms and any changes will be made available to you. I have reviewed and understand the HIPAA policies of this office.

Payment Requirements: Appointments must be paid for at time of service. We accept check, cash, or Traveler's checks, letter of protection from your attorney, most Health Insurance, PIP insurance. Please contact bookkeeping for more details. You will be charged a \$35 fee for returned checks. Any services rendered at the Clinic or additional Lab work must be paid and kept current. You are responsible to make sure you have all lab and diagnostic test preformed at facility of your choice and you should make sure that your insurance covers where you chose to go. It is not our office responsibility to know where your insurance company covers lab or diagnostic testing (You will need to confirm with them to make sure if covered or not). All lab work, diagnostic testing, and prescriptions are giving for your condition. Some insurance does not pay for different medications, and pays for different quantities i.e. standard 1-30 day supply or 90 day maintenance drugs. This office will fill out normal prescription for needed medications however any additional form/s your insurance may necessitate will require payment from you to fill out. If additional forms are required it is your responsibility to supply our office with said forms. This policy is necessary for us to keep cost down. The fee will be a minimum of \$25.00 if you want our office to handle this for you otherwise you can handle on your own with our prescription. Your insurance company may reimburse you for their required paperwork, but that is between you and your insurance.

Appointments: We require **24 hour advanced notice** if you need to change or cancel your appointment. You will be charged a fee of \$40.00 for a missed appointment if office was not notified 24 hour advance cancellation policy was not met. **Records: We maintain a file of your records.** Patients are given their patient records upon written request and first copy is no charge. Subsequent copies are \$1.00 per page for the first 15 pages then .25 cents per page plus postage. Due to my privacy I want to pick up my records or have them mailed only upon written request (Cross out if you prefer all records sent regularly instead of when you want them sent).

If applicable I want all records to be supplied to my attorney of record. We will furnish you with a copy of your medical records upon your signing an authorization form and returning it to our records department. Please allow a minimum of 7 working days for us to process the request. We will not disclose your record to others unless you direct us to do so or unless the law authorizes us to. All employees and business associates are held to all Federal HIPAA compliance rules.

Insurance and Medicare is a contract between you and them: Advanced Care Physicians Group, P.A. does not bill Medicare or Medicaid for auto accident or work related accidents. Otherwise we will bill **Medicare or Medicaid when applicable.** We do have staff available to answer any of your HIPAA and insurance questions.

A photocopy of this agreement shall be considered as effective and valid as the original.

I understand that I will have asked a practitioner of the Advanced Care Physicians Group, P.A. for help if I did not understand any of the above and that he/she answered my questions if any to my satisfaction prior to me signing below.

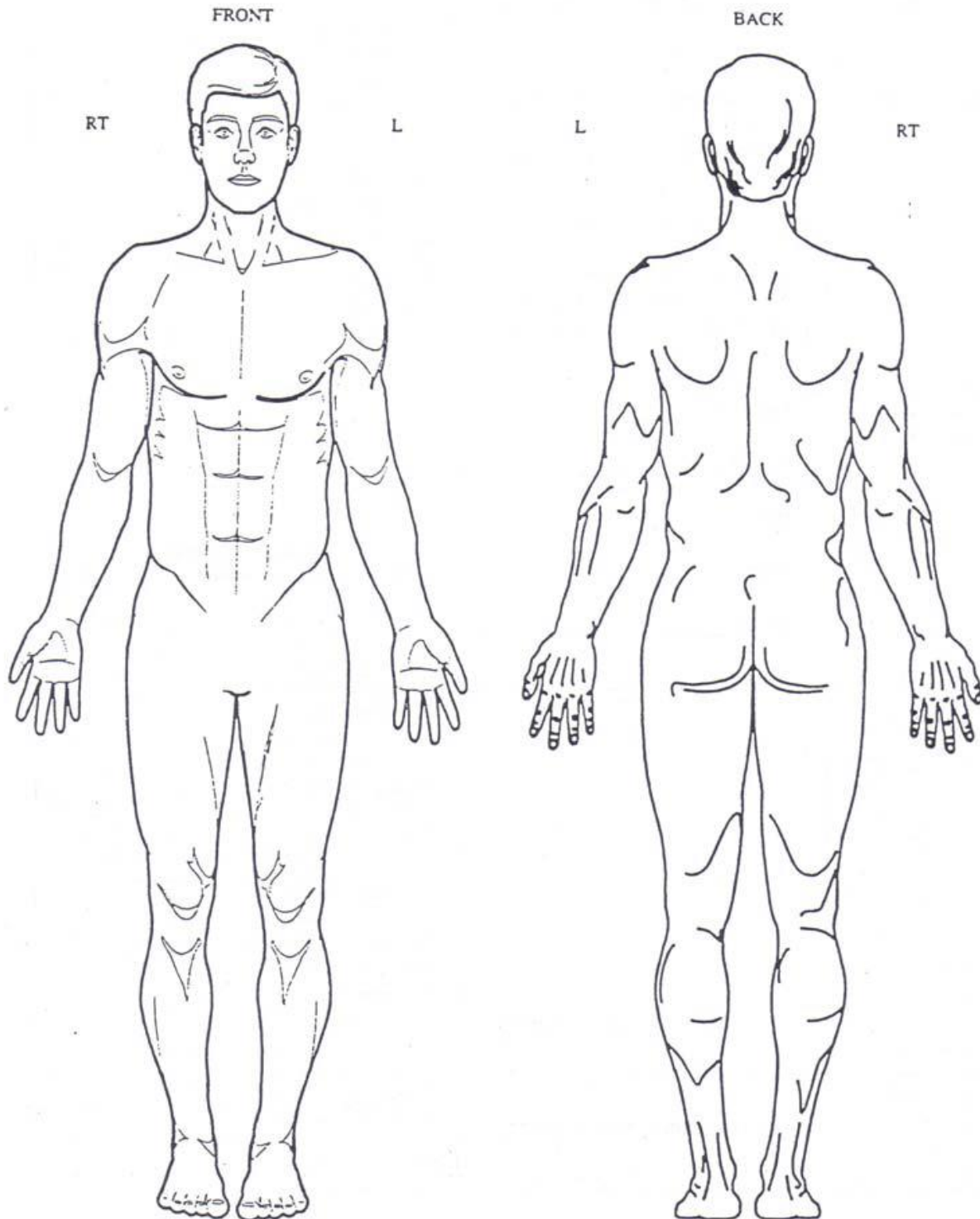
I have read and understand the above statements.

Print Name

Signature (signed by guardian if under-age)

Date

Please Mark all areas where you have pain



Please mark ALL areas where you are having pain. Patient: _____

Date: _____